

MARYLAND STATE DEPARTMENT OF HEALTH

08047

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 252

1. PLACE OF DEATH- COUNTY <i>Queen Anne.</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <i>Maryland</i> COUNTY <i>Queen Anne.</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Centreville</i>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Centreville</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <i>Kidwell Ave.</i>	
3. NAME OF DECEASED (Type or Print)	(First) <i>Charles</i>	(Middle) <i>Carroll</i>	(Last) <i>Connolly</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Oct. 29, 1883</i>
9. AGE last birthday <i>71</i> yrs.		10. UNDER 1 year Months <i>6</i> Days <i>6</i> Hours <i>19</i> Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farm.</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Francis Connolly</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Ellen Golt.</i>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <i>216-20-7463-A</i>	
17. INFORMANT AND ADDRESS <i>Daughter Mrs. Rita Eyring, Baltimore, Md.</i>			

13. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1 Immediate cause (a) <i>Acute congestive heart failure.</i>	INTERVAL BETWEEN ONSET AND DEATH <i>15 min.</i>
Antecedent cause(s) (b) <i>Myocardial insufficiency</i>	<i>3 mos.</i>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <i>Arteriosclerotic cardiovascular disease</i>	<i>Years.</i>

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *June*, 19*55*, to *Aug. 6*, 19*55*, that I last saw the deceased alive on *Aug. 4*, 19*55*, and that death occurred at *11:30 A.* m., from the causes and on the date stated above.

SIGNATURE *D. W. Martin, Jr.* (Degree or title) *MD.* ADDRESS *Queenstown, Md.* DATE SIGNED *Aug. 6, 1955*

23. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	DATE THEREOF <i>Aug 9, 1955</i>	NAME OF CEMETERY OR CREMATORY <i>St. Josephs Church</i>	LOCATION (City, town, or county) (State) <i>Chesora Talbot Co. Md.</i>
DATE REC'D BY LOCAL REG. <i>8-8-55</i>	REGISTRAR'S SIGNATURE <i>Clara Armstrong</i>	24. FUNERAL DIRECTOR <i>Barton Bros. Centreville Md.</i>	ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 23 1955

BUREAU V. 1

8045

CERTIFICATE OF DEATH

Reg. Dist. No. 254

1. PLACE OF DEATH:

COUNTY Queen Anne's MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town) Laurensville LENGTH OF STAY (In this place) Life
 OR TOWN Laurensville
 HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Queen Anne's
 CITY (If outside corporate limits, write RURAL and give nearest town) Laurensville
 OR TOWN Laurensville
 STREET ADDRESS (If rural, give location) 1

3. NAME OF DECEASED:

(First) (Middle) (Last)
EDWARD EARLE COURSEY

4. DATE OF DEATH:

(Month) (Day) (Year)
Aug 2 1951

5. SEX:

Male

6. COLOR OR RACE:

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

Married

8. DATE OF BIRTH:

March 4 - 1891

9. AGE last birthday:

60 yrs.

IF UNDER 1 YEAR IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10b. KIND OF BUSINESS OR INDUSTRY

Public official

11. BIRTHPLACE (State or foreign country):

Groomville Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME:

Charles Earle Coursey

14. MOTHER'S MAIDEN NAME:

Alise Virginia R Loder

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

Yes WW#1

16. SOCIAL SECURITY No.:

none

17. INFORMANT & ADDRESS:

Mrs. Katherine L Coursey Groomville Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

451X
 Immediate cause

(a) DUE TO

Ruptured Aortic aneurysm

Antecedent cause(s)

(b) DUE TO

Advised arteriosclerosis.

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)
 INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
 OF INJURY

INJURY OCCURRED
 While at Not while
 work ☐ at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased give an....., 19....., and that death occurred at.....m., from the causes and on the date stated above.

SIGNATURE

W. D. Schmidt

DEGREE OR TITLE

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Aug. 4 - 1951
Helen M. Aldridge

Barton Bros
Antietam Maryland

MARGIN RESERVED FOR BINDING

RECEIVED

AUG 15 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1808049

8046

CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Queen Anne</u>		MARYLAND <u>Ind.</u>		STATE <u>Ind.</u>		COUNTY <u>Queen Anne</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Inglewood</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Inglewood</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>SARAH REBECCA FURBUSH</u>				OF DEATH: <u>Aug. 3</u> 19 <u>55</u>			
5. SEX: <u>F.</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE MARRIED, WIDOWED DIVORCED. <u>WIDOWED</u>	8. DATE OF BIRTH: <u>June 3-1883</u>	9. AGE last birthday <u>72</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY: <u>USA</u>	
13. FATHER'S NAME: <u>James Wiggins</u>				14. MOTHER'S MAIDEN NAME: <u>Sarah Everett</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Alvin Furbush - Crumpton</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebral Vasculature</u>						<u>1 hour</u>	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Cerebral Arteriosclerosis</u>						<u>Years</u>	
(C) <u>Hypertension Cerebral Vasculature</u>						<u>Years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>None</u>							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Aug 3, 1953</u> to <u>Aug 3, 1955</u> , that I last saw the deceased alive on <u>Aug 3, 1955</u> , and that death occurred at <u>7:30</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Edgar L. Kane</u>				ADDRESS <u>Centerville Ind</u>		DATE SIGNED <u>8-5-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>Aug 6</u>		<u>Sudburyville</u>		<u>Sudburyville Ind</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		FUNERAL DIRECTOR		ADDRESS	
<u>Aug 5</u>		<u>Edgar L. Kane</u>		<u>Edgar L. Kane - Church Hill, Ind.</u>			

BUREAU V. 2.

AUG 15 1955

RECEIVED

Reg. Dist. No. 223

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Queen Anne's</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Queen Anne's</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR	
X TOWN <u>Rural Chester</u>	<u>1 week</u>	TOWN <u>Rural Centerville</u>	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	<u>1</u>
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH:	
(Type or Print) <u>ANNIE BROWN GRIFFIN</u>		<u>Aug 11 1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>Caucasian</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Mar ? 1885</u>
9. AGE last birthday: <u>70</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Newsvendor</u>	
11. BIRTHPLACE (State or foreign country): <u>in Centerville 20 E Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Saleman Brown</u>		14. MOTHER'S MAIDEN NAME: <u>Margaret Jackson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service): <u>no</u>		16. SOCIAL SECURITY NO.: <u>none</u>	
17. INFORMANT & ADDRESS: <u>Josephine Brown Chester Md</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: <u>570.5</u>			
IMMEDIATE CAUSE			
ANTECEDENT CAUSE (S):			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7/4</u> , 19 <u>55</u> , to <u>8/11</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>8/4</u> , 19 <u>55</u> , and that death occurred at <u>0225</u> A.M., from the causes and on the date stated above.			
SIGNATURE <u>H. J. Hoffman</u>		M.D. <u>Centerville Md</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY): <u>Burial</u>		DATE THEREOF: <u>Aug 13-55</u>	
NAME OF CEMETERY OR CREMATORY: <u>Brownsville</u>		LOCATION (City, town, or county) (State): <u>Centerville Md</u>	
DATE REC'D BY LOCAL REGISTRAR: <u>Aug 13, 1955</u>		REGISTRAR'S SIGNATURE: <u>Elizabeth Hopton</u>	
24. FUNERAL DIRECTOR: <u>Barton Bros</u>		ADDRESS: <u>Centerville Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct are is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

AUG 17 1955

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

08051

Reg. Dist. No. 254

1. PLACE OF DEATH COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Queen Anne</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural - Grasonville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural - Grasonville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>		STREET ADDRESS (If rural, give location) <u>1</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Bertha</u>	(Middle) <u>Wilson</u>	(Last) <u>Hargraves</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 11, 1893</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	9. AGE last birthday <u>62</u> yrs. <u>2</u> months <u>1</u> day
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Hadrick</u>		14. MOTHER'S MAIDEN NAME <u>Saddelia</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-03-7534</u>	
(If yes, give war or dates of service)		17. INFORMANT AND ADDRESS <u>Daughter Phila., Penna.</u>	
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause <u>162X</u> (a) <u>Myocardial insufficiency</u>			<u>3-4 days</u>
Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Pulmonary edema</u>			<u>6-7 days</u>
(c) <u>Bronchogenic carcinoma</u>			<u>12 mo.</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June</u> , 19 <u>55</u> , to <u>Aug. 12</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Aug. 12</u> , 19 <u>55</u> , and that death occurred at <u>11:55 P</u> m., from the causes and on the date stated above.			
SIGNATURE <u>G. Wm. Martin, Jr. M.D.</u>		ADDRESS <u>Queenstown, Md.</u>	
DATE SIGNED <u>8/12/55</u>			
23. BURIAL, CREMATION REMOVAL, (Specify) <u>Buried</u>		DATE THEREOF <u>Aug 16-1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Burgess Chapel Cemetery, Queenstown, Md.</u>		LOCATION (City, town, or county) (State) <u>Queenstown, Md.</u>	
24. FUNERAL DIRECTOR REG. <u>Aug 16-1955</u>		FUNERAL DIRECTOR'S SIGNATURE <u>John W. Williams, Esq., Md.</u>	

RECEIVED

AUG 22 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8349
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08052
Reg. Dist.

No. 252

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>QUEEN ANNE'S</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>QUEEN ANNE'S</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR			
X TOWN <u>RURAL CENTREVILLE</u>		<u>2 yrs.</u>		TOWN <u>RURAL CENTREVILLE</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
1. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
(First)		(Middle)		(Last)		(Month) (Day) (Year)	
<u>EDWARD</u>		<u>DEVINE</u>		<u>KERNS JR</u>		<u>Aug. 23 1955</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED.	8. DATE OF BIRTH:	9. AGE last birthday:	10. BIRTHPLACE (State or foreign country):		11. CITIZEN OF WHAT COUNTRY?
<u>Male</u>	<u>White</u>	<u>MARRIED</u>	<u>Sept. 7 1920</u>	<u>34 yrs.</u>	<u>MARYLAND</u>		<u>U.S.A.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>SALESMAN</u>		<u>Mill WORK</u>		<u>MARYLAND</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>EDWARD D. KERNS JR</u>				<u>MANILA H. DAVIS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:			
<u>Yes</u> <u>WWII</u>				<u>220-05-2331</u>			
17. INFORMANT & ADDRESS:				18. MEDICAL CERTIFICATION			
<u>MRS Mildred CARROLL KERNS, CENTREVILLE, Md.</u>				1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			
				Interval BETWEEN ONSET AND DEATH			
				Immediate cause (a) <u>Drowning (accidental)</u>			
				DUE TO			
				Antecedent cause(s) (b)			
				Diseases or conditions, if any, giving rise to the above cause DUE TO			
				stating underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town)		(County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED			
<u>W. Henry Fisher, Centerville Md.</u>				<u>8/24-55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>Aug 25 1955</u>		<u>SATERS CEMETERY</u>		<u>Baltimore County, Maryland</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>8-25-55</u>		<u>W. H. Armstrong</u>		<u>BARTON BROS. CENTREVILLE</u>		<u>MARYLAND</u>	

REAU V. S.

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RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information fully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 251

1. PLACE OF DEATH: <input checked="" type="checkbox"/> COUNTY <u>Queen Anne</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>near Sudlersville</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>md</u> COUNTY <u>Queen Anne</u> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Sudlersville R F 4</u> <input checked="" type="checkbox"/>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (Type or Print) <u>Wm</u> (First) <u>Scott</u> (Middle) <u>Roberts</u> (Last)				4. DATE OF DEATH <u>Aug</u> (Month) <u>24</u> (Day) <u>1953</u> (Year)			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH: <u>Nov 5 - 1888</u>	
9a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Farming</u>		9. AGE last birthday: <u>66</u> yrs.		11. BIRTHPLACE (State or foreign country): <u>md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME: <u>Fredley Roberts</u>		14. MOTHER'S MAIDEN NAME: <u>Annanta Price</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u> (If Yes, give war or dates of service)	
16. SOCIAL SECURITY No.: <u>none</u>		17. INFORMANT & ADDRESS: <u>Min Ella Roberts - sister Sudlersville md</u>		18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				INTERVAL BETWEEN ONSET AND DEATH			
Immediate cause (a) <u>Cardio-renal disease</u> DUE TO							
Antecedent cause(s) (b) <u>giving rise to the above cause</u> DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>W. J. Henry Fisher M.D. Centerville Md.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>8/25-53</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>Aug 27</u>		NAME OF CEMETERY OR CREMATORY <u>Sudlersville</u>		LOCATION (City, town, or county) (State) <u>Sudlersville Md.</u>	
DATE REC'D BY LOCAL REG. <u>Aug 25</u>		REGISTRAR'S SIGNATURE <u>Edgar L. Rane</u>		24. FUNERAL DIRECTOR <u>Edgar L. Rane</u>		ADDRESS <u>Church Hill Md.</u>	

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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08054
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 254

1. PLACE OF DEATH: COUNTY <u>Queen Anne's</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) X TOWN <u>near Carmichael Md</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Md</u> COUNTY <u>Caroline</u> CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Ridgely</u> 057-50 STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) <u>Robert Melvin Smith</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Aug 20 1955</u>	
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>cal</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <u>OCT 30-1911</u>
9. AGE last birthday: <u>43</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Laborer</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Alec Smith</u>		14. MOTHER'S MAIDEN NAME: <u>Emma Patters</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>248-24-4266</u>	
17. INFORMANT & ADDRESS: <u>Elsie Triffin-Ridgely Md</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: <u>92.1X</u> Immediate cause (a) <u>Gunshot wound of chest - Homo cide</u> DUE TO Antecedent cause(s) (b) <u>giving rise to the above cause</u> DUE TO stating underlying cause last (c)		INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		21. HOW DID INJURY OCCUR?	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)	
21c. (City or town) (County) (State) <u>near Carmichael 2a Md</u>		21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Aug 20-1955 7 P.M.</u>	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> . SIGNATURE <u>W. Henry Fisher M.D. - Centerville Md.</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>8/22-55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>Aug 21-1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Barton Burying Ground</u>		LOCATION (City, town, or county) (State) <u>Centerville, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>Aug. 21-1955</u>		REGISTRAR'S SIGNATURE <u>Walter M. Aldridge</u>	
24. FUNERAL DIRECTOR <u>Barton Burying Ground</u>		ADDRESS <u>Centerville, Maryland</u>	

(A)

(I)

SEP

8051

CERTIFICATE OF DEATH

Reg. Dist. No. 254

1. PLACE OF DEATH:

COUNTY Queen Anne's MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town) 1 month
 OR Rural Queenstown
 HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE North Carolina COUNTY Burton
 CITY (If outside corporate limits, write RURAL and give nearest town) Black Mountain 70X-3
 OR TOWN
 STREET ADDRESS (If rural give location)

3. NAME OF DECEASED:

(First) (Middle) (Last)
JAMES EDWARD SWEETESTER

4. DATE OF DEATH: (Month) (Day) (Year)
August 9 1955

5. SEX:

6. COLOR OR RACE:
Male White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH:

Nov-24-1886

9. AGE last birthday: 68 yrs. Months Days Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Retired

10b. KIND OF BUSINESS OR INDUSTRY: Hardware Store

11. BIRTHPLACE (State or foreign country): 2A Co. Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME:

James Edward Sweetester

14. MOTHER'S MAIDEN NAME:

Rachael Van Sant

15. WAS DECEASED EVER IN U.S. ARMY OR FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No

16. SOCIAL SECURITY NO.: 241-05-4641

17. INFORMANT & ADDRESS:

Mrs. Olin Jarrell Queenstown Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

434.2
 Immediate cause

(a) DUE TO

Acute Cardiac Dilatation

Antecedent causes(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) DUE TO

Cardiac asthma

(c)

Interval Between Onset And Death

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY ?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/7, 1955, to 8/9, 1955, that I last saw the deceased

alive on 8/8, 1955, and that death occurred at 4:00 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

W. Henry Fisher M.D.

Centerville Md.

8/10-55

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Aug-10-55 John M. Aldridge

Baithers Bros Centerville Maryland

1007

BUREAU V. S.

AUG 15 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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Reg. Dist. No. 254

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH: COUNTY <u>Queen Anne</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) - TOWN <u>near Carmichael</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>md</u> COUNTY <u>Queen Anne</u> CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Queenstown RFD</u> STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (Type or Print) <u>Elizabeth</u>		(First) (Middle) (Last) <u>Warner</u>		4. DATE OF DEATH <u>Aug 20</u> 19 <u>55</u>		(Month) (Day) (Year)	
5. SEX: <u>Female</u>		6. COLOR OF RACE: <u>Cauc</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (S) <u>Single</u>		8. DATE OF BIRTH: <u>9/12/1921</u>	
9. AGE last birthday: <u>33</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Labour</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Cannery</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME: <u>Wm Warner</u>			
14. MOTHER'S MARDEN NAME: <u>Carrie Bell</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)			
16. SOCIAL SECURITY No.: <u>Wm Warner</u>				17. INFORMANT & ADDRESS: <u>Queenstown</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: <u>981X</u> Immediate cause (a) <u>Gun shot wound through heart</u> DUE TO Antecedent cause(s) (b) <u>right lung - otomocida-</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)						INTERVAL BETWEEN ONSET AND DEATH	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			
21b. PLACE (Home, farm, factory, street, office bldg, etc.) INJURY				21c. (City or town) (County) (State) <u>near Carmichael - 2. A - md</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Aug 20, 1955 7 P.M.</u>				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			
21f. HOW DID INJURY OCCUR?							
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> . SIGNATURE <u>W. Henry Fisher M.D.</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>8/22-55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>							
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u> DATE THEREOF <u>Aug 23</u> NAME OF CEMETERY OR CREMATORY <u>Boston Cemetery</u> LOCATION (City, town, or county) (State) <u>Boston, Maryland</u>							
24. FUNERAL DIRECTOR ADDRESS DATE REC'D BY LOCAL REG. <u>Aug 21 1955</u> REGISTRAR'S SIGNATURE <u>Helen M. Aldridge</u> <u>Boston, Bess. Cemetery - Md. Maryland</u>							

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